

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

0 1 — 0 0 3

2. STATE:

GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

~~XXXXXX~~ March 29, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.272

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 24,714,953  
b. FFY 2002 \$ 32,953,271

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19-A, pp. 78c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

ATTACHMENT 4.19-A, pp. 78c

10. SUBJECT OF AMENDMENT:

INPATIENT HOSPITAL - UPL IN-PATIENT HOSPITAL PAYMENT RATES

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Mark Trail

14. TITLE:

Acting Director, Division of Medical Assistance

15. DATE SUBMITTED:

16. RETURN TO:

Georgia Community Health  
Division of Medical Assistance  
2 Peachtree Street, N.W.  
Atlanta, Georgia 30303-3159

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

March 29, 2001

18. DATE APPROVED:

December 20, 2001

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

March 29, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Eugene A. Grasser

22. TITLE: Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

---

---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

For payments made for services provided on or after March 29, 2001, subject to the availability of funds in the year in which the interim and final rate is paid, State government-owned or operated facilities, non-State government owned or operated facilities and Critical Access eligible hospitals which meet departmental requirements will be eligible for rate payment adjustments. The rate adjustment payments are intended to provide supplemental funding for Medicaid services to these facilities that, based on their status as government owned or operated, need sufficient funds for their commitments to meet the healthcare needs of all members of their communities. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. If sufficient funds are not available to provide maximum allowable payment amounts, rate adjustment payments may be reduced proportionally among facilities eligible to receive payment.

The rate payment adjustments will be subject to federal upper payment limits. For the appropriate groupings of State government-owned or operated facilities, non-State government owned or operated facilities and all other facilities, aggregate rate adjustment payments available without exceeding upper payment limits will be determined by measuring the difference between:

- Amounts paid for services provided to Medicaid patients and
- Estimated payment amounts for such services if payments were based on Medicare payment principles. Either cost based or rate payment measures may be used as Medicare payment principles.

Comparisons of amounts paid for services provided to Medicaid patients and estimated payment amounts for such services if payments were based on Medicare payment principles will also be made for each facility to determine facility-specific rate adjustment payments. If an individual facility cannot be paid a portion of its full rate adjustment payment due to a facility-specific charge limit, this rate adjustment amount can be allocated to other facilities that are eligible to receive additional rate adjustment payments without exceeding facility-specific charge limits. These rate payment adjustments will be made on a monthly, quarterly or annual basis and will be determined in a manner that will not duplicate compensation provided from payments for individual patient claims.

An example of how a rate adjustment payment could be calculated is presented on the following page.

78c

---



---

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
INPATIENT SERVICES

Facility Name	XYZ Hospital
1 Payments for services provided to Medicaid patients during calendar year 2000 as of March 31, 2001	756,620
2 Total charges for services provided to Medicaid patients during calendar year 2000 as of March 31, 2001	1,218,489
3 Statewide adjustment factor for additional calendar year 2000 services paid after March 31, 2001	117.443%
4 Adjustment for inflation between base period (calendar year 2000) and payment period (CY2001)	103.0%
5 Estimated Medicaid payments for patient services in CY 2001 (line 1 x line 3 x line 4)	915,255
6 Estimated current rate adjustment payments for funding from the Georgia Department of Human Resources or the Georgia Board for Physician Workforce	0
7 Estimated total Medicaid payments for CY 2001 (line 5 + line 6)	915,255
8 Estimated total Medicaid charges for CY 2001 (line 2 x line 3 x line 4)	1,473,961
9 Statewide adjustment factor for difference between Medicare and Medicaid DRG rates	131.2%
10 Estimated payments for services to Medicaid patients based on Medicare DRG rates (line 5 x line 9)	1,200,815
11 Facility-specific limit at 150% of payments based on Medicare DRG rates (line 10 x 150%)	1,801,223
12 Lower of total charges or 150% of payments based on Medicare DRG rates (< of line 8 or line 11)	1,473,961
13 Maximum facility-specific annual upper payment limit rate adjustment (line 12 - line 7)	558,706

78d

TN No. 01-003  
Supersedes  
TN No. New

Approval Date DEC 20 2001

Effective Date MAR 20 2001